V. 2, post Retreat

Canadian Society of Addiction Medicine
La Société Médicale Canadienne sur l'Addiction

DRAFT STRATEGY

Discussion Document for Comprehensive Review Committee Attention Only

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Introduction

The Canadian Society of Addiction Medicine's (CSAM's) primary goals have been to: advance health professionals' education in the field of addiction medicine by developing and providing courses and conferences, conducting research and establishing clinical standards; and to educate the public about the assessment, treatment and prevention of addiction by collecting, and disseminating relevant information.

CSAM has plans to go beyond education as its primary mission, to include a role in patient advocacy that influences relevant legislation and policies. As it does so, the Society's leadership is looking to refresh its governance model and to reflect on its mandate, role and future priorities.

A Comprehensive Review Committee (CRC) comprised of 7 CSAM Board members (right) is overseeing the overall strategy development process.

Comprehensive Review Committee
Melanie Willows
Nady el-Guebaly
Wiplove Lamba
George Budd
Claudette Chase
Paul Sobey
Jennifer Brasch

- The process began with externally-facilitated, preliminary consultations that engaged a small number of stakeholders and opinion leaders. In an April 30th teleconference meeting, CRC members discussed an anonymous synopsis of findings from those consultations[1].
- The consultation findings and the CRC's insights informed design for a brief survey administered to almost 600 CSAM members between May 15th and Friday May 24th. On May 22nd, the CRC reviewed preliminary survey findings.
- CRC members were then asked to consider the full Membership Survey findings[2] and the earlier Stakeholder Interview findings and suggest potential Strategic Directions. Five members sent what they perceived to be broad themes that could be considered as potential Strategic Directions during the June CRC retreat in Calgary.
- A Facilitator-prepared composite of all submitted suggestions indicated that 4 Strategic Directions would be developed for the retreat: (Input from a subsequent submission was added to the composite which appears in Appendix A of this document.)

> Educating Health Professionals
>
> Promoting and Disseminating Better Practices
>
> Convening Tables for Dialogue & Consensus Building
>
> Advocating for Meaningful Change

There was consensus that the Facilitator would work with the CRC's May input in the context of the consultation findings, to rough out outcome and action-oriented elements for each Strategic Direction.

What follows reflects enhancements to that work that the CRC identified during its facilitated working session held June 15th in Calgary:

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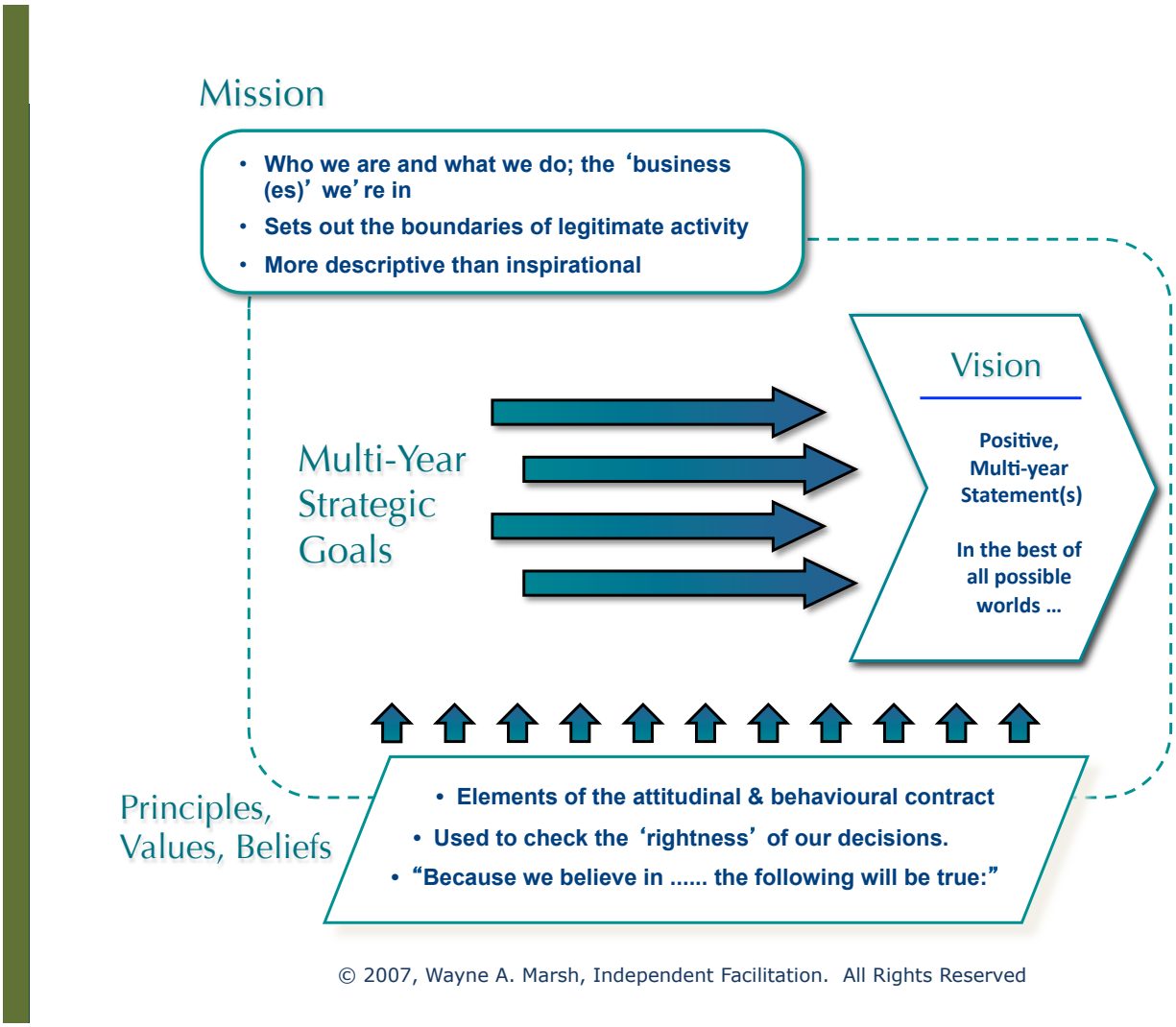
1 The reader should consult that 23-page report for a full description of the approach and findings.

2 https://www.surveymonkey.com/results/SM-V6CW95CPV/.

Inside

The Strategic Elements

It is important to 'sort wheat from chaff' relative to planning jargon, and to understand the unique contributions of each strategic element.



With one eye on the graphic above, consider <u>what</u> each element is:

The **Mission** should be an enduring and descriptive statement that sets the boundaries of legitimate activity ... i.e. who we are and what we do.

One usually has a handful of **Strategic Goals** (a.k.a. Strategic Directions, Strategic Priorities, Broad Goals, Focus Areas) ... essentially broad-based platforms for change ... that guide nearer term priority setting and operational planning.

The **Vision** is a compelling statement of aspirations within the boundaries of the Mission ... a stretch, a rallying cry for change within a longer term horizon.

Values convey what we stand for, what should characterize our attitudes, decisions, and behaviours. They are used to monitor the 'rightness' of day-to-day decisions, as well as longer-term strategic choices.

The Strategic Elements (cont'd)

As part of the June session, the CRC used the foregoing template to consider CSAM's Mission, Vision and Values for the future. They also revisited stakeholders' perceptions (repeated in Appendix B) of what makes CSAM distinctive.

Definition of Terms	Current	Drafts generated at the Retreat
Mission: An enduring and descriptive 1-sentence statement that describes the reason CSAM exists; sets the boundaries of legitimate activity ... i.e. *who we are and what we do*. CLEAR: Simple language, grade 8-10 reading level CONCISE: No fluff. Aim for 5 -14 words (20 max.) USEFUL: Inform. Focus. Guide.	To advance health professionals' education in the field of addiction medicine by developing and providing courses and conferences, conducting research and establishing clinical standards; and To educate the public about the assessment, treatment and prevention of addiction by collecting, and disseminating relevant information	To advance the understanding and treatment of substance-related and behavioural addictions
Vision: A 1-sentence statement describing the desired end-state (in the present tense as if it already exists); the clear and inspirational, long-term desired change resulting from CSAM's work. CLEAR: As above CONCISE: Aim for 10 -15 words INSPIRATIONAL: A compelling statement of aspirations. A stretch. A rallying cry for change.		Hope and dignity for all touched by addictions
Values: The source of CSAM's distinctiveness. What we stand for, what should characterize our attitudes, decisions, and behaviours. CLEAR & CONCISE: As above AGGRESSIVELY AUTHENTIC: Deeply-ingrained principles that guide all of CSAM's actions; cornerstones that can never be compromised. Must be maintained at all costs. USEFUL: For monitoring the 'rightness' of day-to-day decisions, as well as longer-term strategic choices.		• Competence • Community (being pro-social/building community) • Collaboration • Justice N.B. Other, less favoured ideas included: collaboration, inclusion, empowerment/self-narrative, commitment to consensus or consensus-building over divisiveness, excellence, innovation & exploration, scholarship, equity, cohesion, compassion, and mutual respect

Strategic Directions …

that handful of broad-based, 3 to 5 year platforms for change that will guide CSAM's nearer term priority setting and operational planning.

CRC members were asked in May to consider the full Membership Survey findings[3] and the earlier Stakeholder Interview findings and to suggest potential strategic directions. They advanced what they perceived to be broad themes that could be considered as potential Strategic Directions for development during the June CRC retreat in Calgary.

A Facilitator-prepared composite of all submitted suggestions (see Appendix A) indicated that 4 Strategic Directions would be developed for the retreat:

Educating Health Professionals

Promoting & Disseminating Better Practices

Convening Tables for Dialogue & Consensus Building

Advocating for Meaningful Change

The Facilitator worked with the CRC's May input in the context of the consultation findings, to draft outcome and action-oriented elements for each Strategic Direction. What follows reflects enhancements that the CRC identified during its facilitated working session held June 15th in Calgary.

This is still a discussion document. More dialogue and Member engagement are needed to make the content as clear, as compelling and as realistic as possible.

[3] https://www.surveymonkey.com/results/SM-V6CW95CPV/.

STRATEGIC DIRECTION 1 Educating Health Professionals

WHAT WE'RE BUILDING ON

- ✓ Education as CSAM's traditional, primary role and the conference as a cornerstone; CSAM has grown through the conference.
- ✓ The Education Committee.

WE ASSUME THAT:

a. CSAM could: foster appropriate knowledge and skills so as to improve health practices pertaining to addictions and other compulsive behaviours; and foster an environment with other bodies to ensure that that takes place.

b. Education should remain our primary role, with a focus on educating health professionals about all aspects of addiction.

c. We must avoid replicating the work of larger and better-funded institutions such as CCSA, CAMH and BCCSU and, that CPD can be a target without replicating other's work.

d. ISAM will continue to provide the certification exam for the near future; CSAM will continue to take advantage of that avenue for the next 5 years.

e. Effectiveness is a key concept relative to education and CSAM will play a primary quality assurance role in that regard.

THE PATH AS WE SEE IT

Over the next # months, we intend to:	Who/when:	We'll know we've been successful when:
1. Determine CSAM's optimal scope of contributions to education (see Critical Success Factor #2 on the next page.) 2. Given the determined scope, create a focus strategy for maximizing leverage: a. Differentiate the target niches by: • Type of practice setting, • Care/service provider roles, • Types of teams, • Leadership roles; b. Conduct needs assessments for each target niche; c. Design or adopt appropriate education methods (e.g. evidence-based plus "lived" experiences; the Journal; dialogues and other to-be-developed approaches)	TBA TBA	✓ Members of the Canadian addictions care community have increased capacity, knowledge, and skills to enhance their roles in addressing priority issues ✓ Addiction is accepted as a core medical competence ✓ The reach of our educational offerings has expanded ✓ Persons coming into contact with health professionals can trust that they have the evidence-based knowledge and skills needed to provide proper treatment. ✓ More people are receiving care at their primary care home ✓ Partnerships with other disciplines and organizations are successful

DIRECTION **1: Educating Health Professionals** (cont'd)

CRITICAL SUCCESS FACTORS

1. Determining the journey to competence.
2. Generally, as 'opportunities' arise, the ideal role(s) for CSAM to play within that journey; i.e. coordinator? facilitator?, clearinghouse? provider? developer? partner?

   Along the same lines, determining the optimal scope of activities, i.e. whether CSAM should play a role in:

   a. Certifying physicians, once the RCPSC and CCFP decide on special designation/education/whatever (Will there be any need to offer certificates, and will anyone want one?);

   b. Supporting certification in addiction core knowledge and skills, for all care disciplines;

   c. Offering approved CME in addiction medicine (e.g. prompting the need for all health care providers to be trained in assessing and treating comorbid medical and psychiatric conditions); and

   d. Promoting specialization and skill development to improve the quality of medical or health practice as it pertains to addiction.

   NOTE: The locus for these activities might be Strategic Direction #4, *Advocating for Meaningful Change.*

3. Maintaining a comprehensive perspective on the landscape of burdens and harms and providing members as well as the broader health professional and research communities with ways of thinking about them.

   Take the opioid guidelines for example (and others being produced in BC). What did CSAM do with those? CSAM should be informing its members and trying to ensure that there's uptake of these sorts of evidence-informed initiatives.

4. Creating and sustaining the capacity to develop and facilitate program delivery throughout the year.

   a. What role might partnerships play?

   b. How do we master the use of multiple media (including coordinating social media) for information-sharing and advancing the application of emerging knowledge, protocols and tools in one's practice?

5. Operationalizing effectiveness.

STRATEGIC DIRECTION 2 Promoting & Disseminating Better Practices

WHAT WE'RE BUILDING ON

- ✓ The collective expertise of our members and their networks.
- ✓ CSAM's 'brand' as established through the conference.

WE ASSUME THAT:

a. Members and others would value a central repository of information on addiction research and treatment.

b. CSAM can play a meaningful role in support of knowledge translation, knowledge exchange, and knowledge dissemination.

c. CSAM is an avenue for Clinician Scientists/clinical and academic expertise

d. In 5 to 7 years, we'll be positioned to be a credible reviewer of guidelines

THE PATH AS WE SEE IT

Over the next # months, we intend to:	Who/ by when:	We'll know we've been successful when:
1. Develop a process to identify within the available guidelines, the key, '20/80'[4]. 2. Define the 'central repository', and then give it form and value-added function to widely: a. Promote evidence-based best practices in addiction care b. Disseminate best practice, research, guidelines and current practices 3. Act as the members' information centre. Collect and curate information about members, positions & vacancies, factors affecting the quality and economies of addiction practice, other issues and trends (e.g. societal costs)	TBA TBA	✓ Members and others consider CSAM a valued resource for information on addiction research and treatment. ✓ CSAM has successfully mobilized researchers, academics, students and young professionals, practitioners, and policy makers to use research results to make informed decisions about health policies, programs, practices and innovation. ✓ Knowledge that we've helped to mobilize, contributes to improving health professionals' practice

CRITICAL SUCCESS FACTORS

1. Identifying efficient and effective dissemination pathways for optimal impact:

a. Getting evidence-based best practices into med school and residency program core curricula?

b. Working with provincial colleges of physicians to get pan-Canadian application of best practices?

c. Bringing together researchers in addictions in Canada to promote connections, collaboration, and sharing of research findings?

d. Promoting dissemination of research findings/knowledge translation in support of evidence-based care for people with addictions?

e. Creating a forum for knowledge translation?

[4] i.e. the 20% of all guidelines that is likely to generate 80% of the patient benefit (because they are pragmatic, evidence-based, easily accessible and usable)

DIRECTION **2 : Promoting & Disseminating Better Practices**

CRITICAL SUCCESS FACTORS (cont'd)

2. Being clear about CSAM's role relative to influencing or leading standards development. Suggested examples have included:
    a. Developing standards for addiction treatment programs. This would be very different work for CSAM, but there is a vacuum to be filled. Perhaps incompatible with and of lesser priority than promoting education of and connections between health care professionals.
    b. Influencing practice standard development and acting as the seal for credible practices.
3. Balancing academic and pragmatic aspects of guideline identification and promotion.

STRATEGIC DIRECTION 3 Convening Tables for Dialogue & Consensus Building

WHAT WE'RE BUILDING ON:

- ✓ Stakeholder feedback that CSAM is "the only national organization that brings potentially all health care workers together. Other national organizations tend to be more fragmented."

WE ASSUME THAT:

a. Consensus could be reached around around major sources of confusion or 'noise' in the Canadian addictions environment, matters that could benefit from convening tables for dialogue[5].

b. There could be some federal/provincial money available to help fund tables.

c. There is a diversity of philosophies and approaches to addictions, without a forum for bridging gaps/lowering silos.

d. We are not now an organization that emphasizes educating the general public or people with lived experience, important as their contributions may be.

THE PATH AS WE SEE IT

Over the next # months, we intend to:	Who/when:	We'll know we've been successful when:
1. Convene relevant players through high-quality conferences and other events (workshops, seminars and webinars); e.g. experts for guideline development as input to the Central Repository (see SD #2)	TBA	Relative to addictions and other compulsive behaviours: ✓ There is heightened social awareness; ✓ CSAM is recognized as a leader and collaborator in facilitating innovative, multi-sectoral approaches to safe, effective and compassionate treatment. We can show that tables we've convened have: ✓ Informed/helped design our education offerings & activities (SD #1) ✓ Informed optimal approaches to dissemination of better practices (SD #2) ✓ Identified/informed topics and issues taken up by our advocacy efforts (SD #4)
2. Establish communities of practice (academics, practitioners, decision-makers) around priority agendas to use research results for making informed decisions about health policies, programs, practices and innovations.	TBA	
3. Introduce a formal member relations function: a. Use effective communications tools (newsletters, website, social media) to engage with the Canadian addictions community and promote knowledge exchange and networking. b. Strategically engage with members and like-minded organizations to produce and disseminate evidence-based position statements on priority issues.	TBA	

[5] The April 2019 *Synopsis of Consultation Findings* identified: confusion around specific substances; around the physician's role in assessing and treating process / behavioural addiction; around what addiction is and optimal outcomes, around approaches to addiction, and around evidence & policy.

DIRECTION **3 : Convening Tables for Dialogue & Consensus Building** (cont'd)

CRITICAL SUCCESS FACTORS

1. Beyond reaching health professionals, learning to become effective at:
    a. Engaging politicians and the public by promoting knowledge translation in support of evidence-based care;
    b. Facilitating coherent, collaborative dialogue and determining what methods will best serve (e.g., Dephi technique? Others?)
2. Avoiding duplication of others' work in reviewing evidence and offering recommendations.
3. Doing much more to nurture/support networking between health care professionals … i.e. afford access to a large network of physicians and allied health professional working in the field of Addiction Medicine.

STRATEGIC DIRECTION

4 Advocating for Meaningful Change

WHAT WE'RE BUILDING ON

- ✓ CSAM's reputation and credibility.
- ✓ The Advocacy Committee
- ✓ Other? (e.g. previous successes with advocacy?)

WE ASSUME THAT:

a. Based on our consultation, stakeholders percieve CSAM to be quiet on the national stage, leaving less qualified organizations to dominate public discussions.

b. CSAM can play a central role in advocating for evidence-based policies and practices within the health care system in general.

c. CSAM has a moral responsibility to start speaking up relative to patient needs, provider community needs, and societal needs.

d. Generally, the intended outcomes will involve influencing public policy around patient rights, access to diagnosis and treatment, research, and adequate resources for all of the foregoing.

e. The term 'position paper' is polarizing. We want to convey a collaborative dynamic.

THE PATH AS WE SEE IT

Over the next # months, we intend to:	Who/when:	We'll know we've been successful when:
1. Via members and work on our other strategic Directions, identify prospective issues and opportunities where CSAM might play an advocacy role.	TBA	STAGE I ✓ We have learned about and understand our most effective role(s) in advocacy
2. Develop an approach/criteria for determining optimal role(s) for CSAM to play … i.e.: c. Taking a lead role in advocacy; vs d. Adding CSAM's voice to those of others leading out on advocacy; vs e. Convening neutral tables where partners or potential partners can dialogue about potential collaborative advocacy strategies (N.B. link to SD #3).	TBA	✓ We have set clear, attainable goals to address issues through those roles ✓ We can see how to secure the resources/capacity to achieve those goals. STAGE II ✓ TBA specifically, depending on what Stage 1 reveals ✓ Generally, we can point to policies and practices that have changed as a result of CSAM's efforts
3. Use education as a tool for advocacy … e.g. educate health care providers and the public so as to foster expectations of a health care system free of stigma. (N.B. link to SD #1)	TBA	✓ CSAM is more visible as an effective and constructive agent for advocacy ✓ Our communication and coordination avoid confusion or redundancy given what other organizations are doing

DIRECTION **4 : Advocating for Meaningful Change** (cont'd)

CRITICAL SUCCESS FACTORS

1. Adopting key principles for determining focus strategies and optimal advocacy approaches. Perhaps liaise with consumer groups for input.

   To the right are issues that Stakeholders flagged as pressing in the Canadian addictions environment today.

   Further, many believe that stigmatization and lack of dignity or respect are central to all problems with addiction and should be a CSAM target for advocacy. They suggest that CSAM explore the concept of stigma and develop a unique approach to addressing it.

   Others say that our efforts should not go to stigma reduction, but to becoming more active in initiatives that promote addiction as a medical condition.

   What do Members think about these choices? Are they mutually exclusive? What principle(s) could guide our thinking?

   A subset of more focused, actionable items in the near term might include:

   - Opioids and indigenous people
   - Cannabis: Addiction prevention and youth
   - Pregnancy and addiction
   - Rural and other underserved populations relative to all of the 'Pressing Issues' above.

   Pressing Issues

   - Opioids
   - Cannabis
   - Alcohol
   - Training & Education for Health Care Workers around Addiction Medicine
   - Crystal Meth
   - E-cigarettes and vaping
   - Safe Injection Rooms
   - Confusing Pathways to Care
   - Access : A 2-Tiered System
   - Physician Remuneration

2. Finding existing, powerful movements for CSAM to get behind with strong, practical actions as well as partners who can help.
3. Ensuring that advocacy-related activities do not compromise CSAM's core values (e.g. use of collaborative and not militant /partisan approaches).
4. Stepping out on contentious issues in ways that are constructive.

CRC thoughts for consideration as the process continues to unfold …

1. A principle would be that where possible, we will leverage existing assets, policies and processes, tweaking as needed to help drive the new Strategy.
2. Consider the By-Laws in light of these emerging strategic intentions. Flag those to be monitored and as needed, determine how they can work together.
3. Look at committee structures to see what changes might be needed to optimize alignment with the Mission, Vision, Values and Strategic Directions: For example, how will this Strategy help guide the Education Committee's activities and targeted outcomes? How do we facilitate diverse involvement of volunteers to give this work some lift? How do we think about accountability to the Board?

   Preliminary Ideas:

   a. Terms of reference can be tailored to roles, responsibilities and operations that align with strategic priorities.
   b. For each Strategic Direction, for THE PATH AS WE SEE IT section, the *Who/By When* column should be populated by *individuals* (perhaps the Chair), *not by* Committees of the whole.
   c. Committees' size and membership mix should be deliberate, to help them be focused, efficient and effective.
   d. Their agendas should be designed, lock-step around standing items with measurable goals and milestones that drive bite-sized (12 to 18-month) chunks of Strategy.
   e. Updates to the Board (or the CRC if it adopts an ongoing steering role) should be formal and user-friendly to foster a common, disciplined approach (see Appendix C for one way to think about this).
4. Anticipate upcoming conferences and seize opportunities for special speakers and/or sessions profiling topics/issues/context relevant to the Strategic Plan.
5. Examine CSAM's resources (particularly financial) in light of what will be needed to support implementation over the next 3 to 5 years (e.g. supporting the President to make connections and go to key meetings).
6. Check: (a) alignment of the implied directions and activities with the roles, capacity, competencies and activities that our current administrative functions support; and (b) what CSAM's financial reality will support.

Immediate Next Steps

June	1-page Board of Directors' Briefing
July-Sept	(assuming Directors' endorsement) 1-page Mission, Vision, Core Values and Strategic Directions to the general membership for feedback. CRC teleconference meetings to continue work on Strategic Directions
October	In-person Board meeting (Halifax): Seek provisional endorsement of Mission, Vision, Core Values, and Strategic Directions with high-level actions. President's conference-opening remarks: Describe process to date and invite CSAM members to 4 facilitated, 1-hr sessions to learn more about and offer feedback on 4 strategic directions. Annual CSAM members' meeting: Vote to approve Mission, Vision, Core Values, and Strategic Directions with high-level actions.

Facilitated by
Wayne A. Marsh
Independent Facilitation Services

Appendix A

The Canadian Society of Addiction Medicine

Strategic Planning Retreat Preparation

Comprehensive Review Committee Thoughts on CSAM Strategic Directions

Review Committee members were asked to consider the: Membership survey findings (https://www.surveymonkey.com/results/SM-V6CW95CPV/.) and the Stakeholder Interview findings.

Six members sent what they perceived to be broad themes that could be considered as potential strategic directions when we convene in June in Calgary.

Here is a compilation of the input received. Implied Strategic Directions (bolded) are followed by related comments. Strategic Directions are listed in descending order of the number of persons that advanced them.

Education (6 respondents)

1. Should remain our primary role. Education methodologies should be expanded. This would include dialogues and other to-be-developed methodologies that do not replicate the work of other larger and better-funded institutions such as CCSA, CAMH and BCCSU.
2. Evidence-based plus "lived" experiences
3. Educating health professionals about all aspects of addiction. Do we have the capacity to develop workshops to be delivered throughout the year?
4. Focus on education of physicians and health care professionals. The CSAM conference is important. Re-evaluate CSAM's role in certification of physicians, once the RCPSC and CCFP decide on special designation/education/whatever. Will there be any need to offer certificates, and will anyone want one? Our role may need to transition to offering approved CME in addiction medicine.
5. Educating health professionals about all aspects of addictions. CSAM may also play a higher role in certifying an addiction specialty for all the care disciplines?

Promoting and disseminating evidence-based best practices (6 respondents)

1. Act as a central repository of information on addiction research and treatment.
2. Disseminate best practice, research, guidelines
3. Promoting evidence-based best practices in addiction care and disseminating this knowledge widely. How do we get it as core curriculum in med schools and residency programs? Do we work with provincial physician colleges to get pan-Canadian application of best practices?
4. Promote dissemination of research findings/knowledge translation in support of evidence-based care for people with addictions. Bring together researchers in addictions in Canada to promote connections, collaboration, sharing research findings.
5. Repository of Information about members, trends, positions and vacancies, economies of practice, costs on society
6. Circulate best practice, research, guidelines, current practices and act as the Information centre for members.

Convening tables for dialogue (4 respondents)

1. Act as a venue for dialogue. Some organizations and venues have become polarized and are increasingly ineffective. Advocacy groups argue their positions or approaches in an unprofessional and occasionally threatening manner. CSAM should provide settings both electronic and in person to promote rational discussions of the issues at hand. Pertinent issues (the role or alcohol and nicotine, access to high quality treatment for youth etc.) are being lost in the vitriol over the opioid epidemic. The dialogues should be documented in some manner in order to reflect a consensus. The information could then be used to coalesce opinion around a certain issue.
2. Social Awareness: Issues and controversies of the day. Position papers and debates.
3. We know health professionals are our target but do we make more of an effort to educate politicians, the public by promoting knowledge translation in support of evidence-based care for people with addictions?
4. Convene tables for dialogue, but avoid duplicating work being done by other organizations in reviewing evidence and offering recommendation. Do much more to nurture/support networking between health care professionals … i.e. afford access to a large network of physicians and allied health professional working in the field of Addiction Medicine. . We are not an organization that places emphasis on educating the general public or people with lived experience, important as their contributions may be.

Advocacy (5 respondents)

1. Advocacy (treatment, stigma)
2. Explore the concept of stigma in order to develop a unique approach to addressing it.
3. Advocacy re: Patient rights, adequate resources, research. Liaise with consumer groups.
4. Change the environment through activism/political activity. Our main goal is not stigma reduction, but taking a more active role in initiatives/promoting addiction as a medical condition should be part of our vision.
5. Advocate and be a political influence and direct politics and public funding
6. Advocate for a health care system fee of stigma by educating health care providers and the public. Be more visible in the media as the addiction advocacy society

Partnerships (2 respondents)

1. Partnerships (with health care providers, individuals with lived experience, other organizations)
2. Closer alliance with PHAC and provincial public health agencies to be more effective. Perhaps create a board position for a public health md.

Developing standards for addiction treatment programs (2 respondents)

1. Consider developing standards for addiction treatment programs, since no one else has. This is very different work than we have done, and perhaps not compatible with promoting education of and connections between health care professionals, which I think are higher priorities
2. Influence practice standard development and act as the seal for credible practices.

Representing licensed healthcare professionals' interests and opinions (1 respondent)

1. Remain an organization that represents the interests and opinions of licensed healthcare professionals.

Appendix B

Excerpts - Stakeholder Consultations

To what extent do you feel that CSAM is distinctive?

There were a number of superlatives:

- ✓ It's the only national organization that brings potentially all health care workers together. Other national organizations tend to be more fragmented.
- ✓ CSAM is the only organization that can claim to represent nationally, addiction clinicians whether they be doctors or nurses or therapists. There are provincial organizations, but none can really make that claim. At least in theory, it has a lot of credibility, and potentially, influence.
- ✓ I've always looked to you as the experts when it comes to addiction medicine; as really promoting specialization and skill development as they pertain to addiction medicine.
- ✓ In many ways, CSAM is the unique professional society for addiction treatment in Canada.

A few specific kudos:

- ✓ … staging a really good conference (under P. Sobey's leadership). CSAM has grown through the conference.
- ✓ CSAM is a knowledge sharing/knowledge exchange society that brings people together to share information, research, and knowledge in the area of addictions at their conferences.
- ✓ CSAM had a hand in developing the Canadian Chapter of the Nursing Society for Addictions; that kind of came out of CSAM and they do the joint sessions at the annual CSAM conference. So, where they exist, CSAM can have connections to the other addictions-related professional bodies.

Some mixed reviews:

- CSAM has good representation of opioid-related harms and if anything, at the annual meeting, there is over-representation of opioid addiction as compared to other forms of addiction.

  There is no equivalent (for example) in psychology. The Canadian Psychological Association does not have a very robust addiction psychology arm or infrastructure. I don't think that other international professional societies have major representation in Canada (e.g. the Research Society on Alcoholism, the College on Problems of Drug Dependence, or the Society for Research on Nicotine and Tobacco). Their scope is broader and more international.
- When I think of CSAM, I think of it as being strongest in terms of providing resources and content around treatment for physician providers, not necessarily non-physician providers as much. And I'm not sure that I associate it as being as rigorous a research body so much as a clinical body.
- Maybe I'm being unfair, but my sense about it is that CSAM has focused on education and primarily their journal and their annual conference.

And a couple of hard knocks:

- ✗ It's only distinctive if people come across it. But regarding the general public or nurses and so forth, they've never heard of CSAM, don't understand what it is, and don't even know that it's out there.

To what extent do you feel that CSAM is distinctive?

Hard knocks: (cont'd)

- The Society is totally absent right now regarding the pressing issues mentioned earlier. I have heard absolutely nothing from CSAM on these. Nothing on the opiate crisis. This is absolutely deplorable.

To what extent do you feel that CSAM will continue to add needed value?

1. When you look at the CSAM Mission Statement, they should have a role with specialization, with physicians, and with health professionals. If access to treatment is an issue, for every other health condition, treatment begins in the GP's office. Why is it not happening in the GP office? This speaks to **CSAM's education role**; how do you facilitate learning so that the physician does more in this area?
2. At some meetings, I've felt like CSAM represents a **comparatively narrow spectrum of providers** … that it's very opioid-focused or perhaps extremely medically focused.

   It could benefit from being broader and covering more addiction landscape and also being potentially more inclusive of not just physicians but also other professionals. Changing the name would be a big move, but not necessarily a bad one because there's no competition; the Canadian landscape is fairly impoverished for professional societies around addiction. It could probably continue to be the go-to society for MDs but could also more broadly have working groups or membership groups for PhDs, MSWs, Nurses.
3. It has an absolutely central role in **advocating for evidence-based policies and practices** within the health care system in general.
4. Perhaps refine the fostering and promoting of research through **knowledge mobilization of what the evidence is saying**. That perhaps is one of the roles of the addiction journal.
5. I think CSAM **still appreciates all the pathways to recovery** and I've not seen it favour (as in polarize around) a particular therapy. I hope that they never do. They've been a little more vocal about all of them in terms of just trying whatever fits.
6. The **conference is almost the raison être** … is THE event … and has always been good.

To what extent do you feel that CSAM could let go of, or discontinue specific traditional activities?

There were fewer thoughts in response to this one.

1. An historic concern has been the lack of information; one respondent can't remember the last time that they received any information from CSAM. You can't grow the organization if the members aren't aware of what's going on. It seems a little bit haphazard. Even when it comes to re-applying, no notifications are received. This person has reached out to say, "I think I must be due."

   That's problematic.
2. Nothing. I like what they've got going on now. Any improvements would just be great.

Appendix C

Periodic Status Reports to the Board

(One Approach)

Strategic Direction _____

Status Legend	= Good progress; outcomes as expected at this time. = Caution. Slightly behind schedule or drifting direction. Corrective action may be needed. = Not yet started/in early development, or major intervention indicated.

Priority Initiatives for this Strategic Direction	Status

Good news / success stories since last report.

Background to, and analysis of any problem(s) since last report + planned tactics to get on track

Goals for next report + request for assistance/support if needed

Strategic Lead: _____

Date: _____